



**MINISTRY OF SOCIAL
DEVELOPMENT**
TE MANATŪ WHAKAHIATO ORA

**EFFECTIVENESS OF
CONTRACTED CASE
MANAGEMENT SERVICES ON
OFF BENEFIT OUTCOMES:
MID-TRIAL REPORT**

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Acronyms

CCMS	Contracted Case Management Service
GCM	General Case Management
HCD	Health Condition or Disability
LLTBR	Likelihood of Long Term Benefit Receipt (statistical risk model)
MHES	Mental Health Employment Service
MSD	Ministry of Social Development
NSDM	New Service Delivery Model
RCT	Randomised Control Trial
SDM	Service Delivery Model
SPES	Sole Parent Employment Service
WFCM	Work Focused Case Management
WFCM Gen	Work Focused Case Management General
WFCM HCD	Work Focused Case Management Health Condition or Disability
WFCM IS	Work Focused Case Management Integrated Service
WSS	Work Search Support
YP	Youth Payment
YPP	Young Parent Payment

Sources

2015 Trial_CT_analysis.xlsx

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modelling\2015_CntrPlc_Trials

1. Overview

This report summarises the impact of two externally contracted case management services, the Mental Health Employment Service (MHES) and the Sole Parent Employment Service (SPES). This report considers outcomes for the first 18 months of the services to 31 March 2015.¹ In particular, this report considers whether being in either of these case management services changed, on average, the amount of time clients spent off main benefit compared to internally provided case management services.

Externally contracted case management services

Service	Regions	Target group for evaluation
SPES	Auckland, Bay of Plenty, Canterbury, East Coast, Nelson, Taranaki, Wellington	Clients receiving Jobseeker Support benefit with full-time work obligations, ¹ not in a relationship and with a youngest child aged 14-17
MHES	Auckland, Canterbury, Southern, Waikato	Clients receiving Jobseeker Support benefit with part-time or deferred work obligations and any depression or stress medical incapacity

Note 1: the evaluation results exclude sole parents with part-time work obligations

Note 2: the evaluation results exclude clients who participated in the MHES after 9 June 2014

Randomised control treatment design

The impact evaluation is based on a randomised control treatment design. For each service, clients who volunteer to participate in a service are randomly assigned to a treatment or control group. The treatment group are referred to a provider, while the control group remain in the internal case management service. The control group represents a counterfactual scenario, what would have happened to the treatment group in the absence of the contracted service.

1.1 Summary of findings

Impact of MHES and SPES on time off main benefit

This analysis considers whether MHES or SPES increased, on average, the total time spent off main benefit in the 12 months after clients started each service compared with similar clients in an internal case management service (WFCM, WSS or GCM).

Note, this analysis does not differentiate between reason for benefit exit (e.g. to employment, migration or prison).

¹ Both the MHES and SPES were introduced in September 2013.

The control group receives active case management assistance as well

Before discussing the results of the evaluation, readers need to understand what we are comparing SPES and MHES against. In both trials, the control group receive a mix of internally run case management services. However, there are significant differences between the two trials in the amount of active case management assistance the control groups received.

Table 1: Number of weeks spent on active service

	Treatment	Control
MHES	22	9
SPES	38	33

Table 1 shows the number of weeks that clients in each of the participant and control groups for the contracted case management services spent on average in active service, either in the external services or in an internal service (i.e. WFCM or WSS).

The key message from Table 1 is that the control group for the SPES spend considerable time in intensive case management services. In other words, for the SPES trial we are comparing external to internal case management models.

In contrast, for the MHES trial, the control group spends relatively little time on active case management. In this case, we are comparing contracted case management to a lower intensity service on average. These differences have implications on how we interpret the findings for each trial.

SPES shows a positive impact on time off main benefit

The results show that SPES was successful in increasing the average time off main benefit. We estimate that in the first 52 weeks after a client is referred to SPES, on average, they spend 8 (± 1.8) fewer days on a main benefit than clients in the control group. Recall from the previous section, that this impact is over and above the impact of internally run case management services received by the control group.²

MHES does not show a positive impact on time off main benefit

Our analysis shows that MHES was unsuccessful in increasing the average time off main benefit. Instead, we estimate that in the first 52 weeks after a client is referred to the service, they spend on average 1 (± 1.4) more days on a main benefit than the clients in the control group. We cannot attribute the lack of impact to the control group receiving a high level of case management support.

² MSD (2015) Effectiveness of intensive case management services (WFCM and WSS) on off benefit outcomes at one year: initial results (version1), Ministry of Social Development

We do not think the lack of impact is necessarily related to the contracted out nature of the case management. The evaluation of internal case management services for clients with health conditions and disabilities also show comparatively modest impacts.³

Duration in contracted services

One important reason for the absence of an impact from MHES is the relatively short time the treatment group spend on the service. We found a high dropout rate for the treatment group. For MHES, 48% of referred clients ended the services within 8 weeks after starting. For the SPES the proportion was 35% (refer Figure 5). Changing the operating model for each service to increase the time participants spend with the external provider may help to improve the effectiveness of each service.

1.2 Next steps

We plan to report on the impacts of the SPES and MHES at the end of the trial i.e. the three year mark. At that point we intend to carry out the following additional analysis:

- calculate the cost-effectiveness (Return on Investment) of SPES and MHES
- address the issue of incomparability between the SPES and MHES due to different counterfactual groups

Additional analysis that could be completed at that time (dependent on resourcing and priorities) are:

- examine whether the impact of services differ across providers
- look at other outcomes, such as employment and earnings as well as income support expenditure
- examine the impact of MHES and SPES on sustained exits from benefit

³ MSD (2015) Effectiveness of intensive case management services (WFCM and WSS) on off benefit outcomes at one year: initial results (version1), Ministry of Social Development

1.3 Limitations of the analysis

Readers should take into account the following limitations of this analysis.

- **Overall effectiveness of contracted case management:** The emphasis in this evaluation is on the difference externally contracted case management makes over and above internal case management. What we did not test is the effectiveness of case management in general.
- **Time off main benefit:** We confine our analysis to the impact of SPES and MHES on the time spent off main benefit (excluding temporary suspensions to benefit entitlement). We do not know whether this reduction is because of increased employment or other, less desirable, outcomes.
- **Non-participant effects:** We were unable to examine whether the impacts on SPES clients came at the expense of other groups. In particular, we do not know whether equivalent clients in internal services spent longer on benefit because of the assistance given to clients in SPES (i.e. crowding out effects). If these non-participant effects occur, then they would offset the impacts reported here.
- **Different providers:** We have tested MHES and SPES as homogenous services. In practice there may be significant variation between providers and there may be some providers who are more or less effective than others.
- **Changes to the services from June 2014:**
 - In June 2014 the SPES was extended to include clients on a Sole Parent Support benefit with a youngest child aged 5-13 years. These clients have not been included in the evaluation, and we are unable to assess the effectiveness of SPES for this client group.
 - From June 2014, no new clients were added to the MHES control group for evaluation purposes. As such, the evaluation of the MHES service only includes outcomes for clients who participated in the service from inception to 9 June 2014.
- **The impact of the SPES and MHES are not comparable:** The counterfactual group for SPES and MHES are not equivalent and therefore the impact for the two services cannot be compared with each other. The majority of the SPES control group have been in the Work Focused Case Management internal service, whereas the majority of the MHES control group have been in the General Case Management internal service (see discussion of results, section 3.1).

2. Background

In this background section, we provide a short outline of the two externally contracted case management services, the broad eligibility criteria for the services, the method used to allocate clients to services and how the effectiveness of each service was evaluated.

2.1 Outline of externally contracted case management services

From September 2013, Work and Income began to trial two contracted case management services (CCMS) for clients with specific needs. These were the Mental Health Employment Service (MHES), for clients with mild to moderate mental health issues, and the Sole Parent Employment Service (SPES) for Jobseeker Support benefit clients with a youngest child aged 14-17 years.

In order to learn from the services, each was set up as randomised control trial (RCT) so that the outcomes of clients in the trials could be compared to the outcomes of similar clients in Work and Income's internal case management services (WFCM, WSS and GCM).

Sole Parent Employment Service (SPES): The SPES service was originally provided for clients on a Jobseeker Support benefit with full-time work obligations who are single and whose youngest child is aged 14-17 years. The service is provided in the Auckland, Bay of Plenty, Canterbury, East Coast, Nelson, Taranaki and Wellington regions.

In June 2014 the SPES was extended to include clients on a Sole Parent Support benefit with a youngest child aged 5-13 years. These clients have not been included in the evaluation, and we are unable to assess the effectiveness of SPES for this client group.

Mental Health Employment Service (MHES): The MHES service is provided for clients who are on a Jobseeker Support benefit with part-time or deferred work obligations, with a recorded incapacity of depression or stress. The service is provided in the Auckland, Canterbury, Southern and Waikato regions.

From June 2014, although clients continued to be referred to providers, no new clients were added to the MHES control group for evaluation purposes.

As such, the evaluation of the MHES service only includes outcomes for clients who participated in the service from inception to 9 June 2014.

2.2 How are clients allocated to the services?

The evaluation team within Insights MSD (IMSD) randomly generates a call list each week of those clients who meet the eligibility criteria for either the MHES or SPES. These clients are contacted by telephone during the week and asked a

question which is designed to gauge the client's willingness to participate in the CCMS.

Once a client is gauged willing to participate, they are randomised into either a 'treatment' group (i.e. they participate in the service) or 'control' group (i.e. they continue with Work and Income services). For every two clients assigned to the treatment group, one client is assigned to the control group. The clients in the treatment group are referred to the contracted provider in their area and the clients in the control group remain in an internal Work and Income case management service.

This method of allocation enabled Insights MSD to evaluate in a robust manner the effectiveness of the external services compared to the internal services.

2.3 How do clients exit the services?

In practice, clients who are referred to a provider are able to exit from the provider's case management and return to Work and Income case management voluntarily. Providers are also able to exit clients from the service where they felt they would be unable to achieve positive outcomes with that client.

Clients who have been with a provider for six months and have been unable to achieve an exit into employment in that time are exited back into the internal Work and Income case management service.

Clients who are assigned to the treatment group for a particular service and who subsequently exit the service for whatever reason, are still included in the treatment group for evaluation purposes. The implications of this approach are discussed in section 2.5 below.

2.4 How have we evaluated the effectiveness of the MHES and SPES?

Built into service allocation is a randomised control trial (RCT) design. The RCT ensures that for clients assigned to a service (the treatment group), a smaller but equivalent⁴ group of clients are not assigned (the control group). Once a client is randomly assigned to the control group for an external service, they remain in their current internal case management service (e.g. GCM, WSS or WFCM). However, they are still able to be selected for other internal case management services for which they are eligible. For example, a MHES control group client in GCM at the time of assignment can still be selected to a WFCM service they are eligible for at any future time.

The combination of control group, nationally defined eligibility rules and evaluation administered service allocation enabled iMSD to provide robust estimates of the impact of MHES and SPES on client off-benefit outcomes.

⁴ Equivalent means they are eligible for referral to the service, have indicated a willingness to participate and are registered at the same Service Centre.

2.5 Clients who exit the service and remain in the treatment group

As discussed earlier, clients who are assigned to the treatment group for a particular service and who subsequently exit the service at any time, for whatever reason, remain in the treatment group for evaluation purposes. This approach was taken for the following reasons.

- 1) The aim of the trial is to identify what difference a voluntary contracted case management service will have on the outcomes of those clients who agree to participate. The impact results of the RCT, combined with the proportion of the eligible population who volunteer to participate, will tell us:
 - the likely overall impact of each service if it is rolled out nationally
 - the required number of spaces for the service, given a realistic take up rate, and the time participants spend in the service.
- 2) The RCT was designed to estimate the impact on clients willing to participate in each of the contracted services (often referred to as an "intention to treat" design). Any difference in the outcomes between the control and treatment group will reflect both the *design* of the service as well as how well each service operated in *practice*. In particular, if a high proportion of clients referred to the provider spend only a short time on the service and return to Service Delivery, this would cause the average impact (also known as the average treatment effect) for the service to be underestimated at the point of referral.
- 3) Clients exiting from a service may introduce unobserved selection effects.⁵ To avoid introducing unobserved selection effects through exits, we continue to include clients who exited from the CCMS service⁶ in our evaluation. In essence, we are testing the impact on off-benefit outcomes for those clients who are referred to the service whether or not they received a different form of case management from the contracted providers.

Impact on participants who remain with the service is not known

The current RCT design cannot answer the question of what impact the service had solely on those clients who spent time in the service (commonly referred to as "treatment on the treated" or TOT). The reason is that these participants are a sub-group of those referred to service (i.e. treatment group) and we expect they would differ in important ways from those who are referred and did not participate. A TOT estimate is essentially seeking to disregard those in the treatment group who did not "properly" take part, considering only those who were exposed to the intervention as intended. Theoretically, we cannot estimate the TOT because we cannot determine which of the control group are valid

⁵ Selection effects are where individuals are selected for a trial in a way which is not random and therefore introduces some bias. In this case the likelihood that a client would exit the trial is not a random characteristic and so cannot be used as a determinant for involvement in the evaluation.

⁶ Including clients who voluntarily exited and those who were exited by the provider.

counterparts to the remaining treatment group⁷ i.e. we cannot know who within the control group would also not have "properly" taken part (if given the opportunity to do so).

2.6 Participants excluded from this analysis

We have excluded a number of participants in the CCMS from the evaluation. These participants were selected for participation in the services (treatment group) but no corresponding control group was set up. As a result, the impact of the services on them cannot be evaluated.

- **Part-time work obligated SPES clients:** In June 2014 the SPES service was extended to sole parents with part-time work obligations. The original eligibility was limited to clients with full-time work obligations. These clients have not been included in this evaluation.
- **MHES clients after June 2014:** Following June 2014 the control group was discontinued for MHES in order to increase the number of referrals to providers of this service. As a result, clients who participated in the MHES from 9 June 2014 are not included in this evaluation. However, a sufficient number of clients participated in the service prior to this date to provide a sense of how the service performs compared to internal case management. The number of clients who are allocated through the RCT determine the accuracy with which we can determine the impact of the service. If more clients had been allocated, the confidence intervals seen in Figure 4 would be much narrower, and we could say with more confidence what the average impact of MHES is.

⁷ CSRE (2012) Good Practice Guide: Experimental Design, Malatest International

3. Analysis

At this initial stage of the evaluation, we look only at the impact of MHES and SPES on the total time clients spend off main benefit.

3.1 Impact on the time clients spend off main benefit

SPES increased the time participants spend off main benefit

Figure 1 shows the cumulative time off main benefit for clients assigned to SPES compared to the off benefit outcomes of similar clients in internal case management. For example, at 52 weeks after starting SPES, we estimate that SPES participants would have spent an average of 14.4 weeks off benefit, compared to control group clients who spent an average of 13.2 weeks off benefit.

Figure 1: Estimated time off main benefit for SPES compared to internal case management

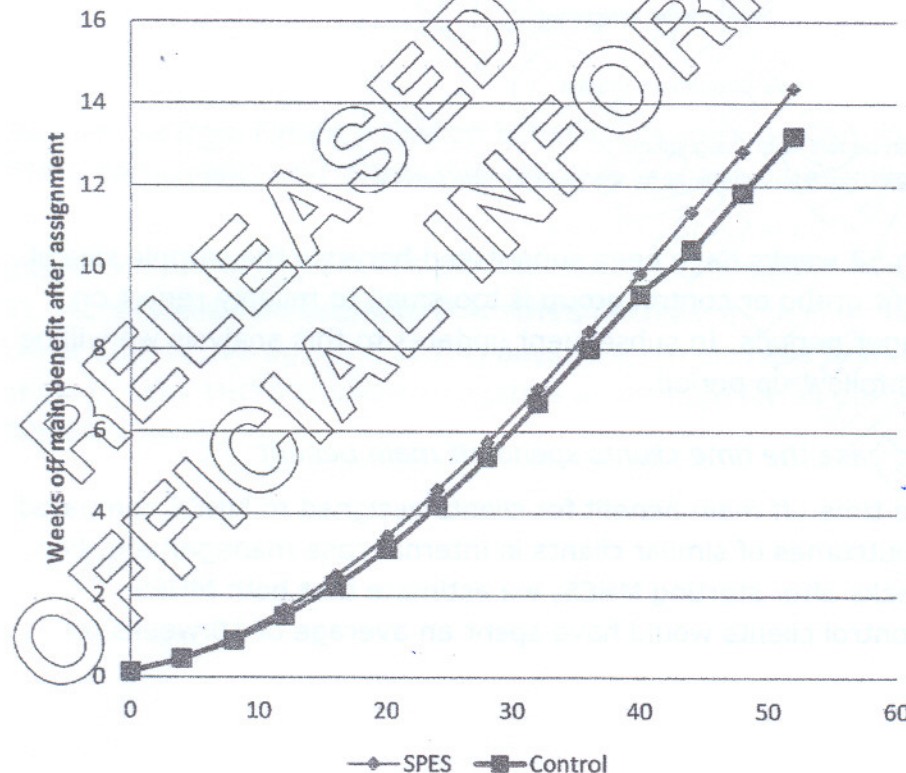
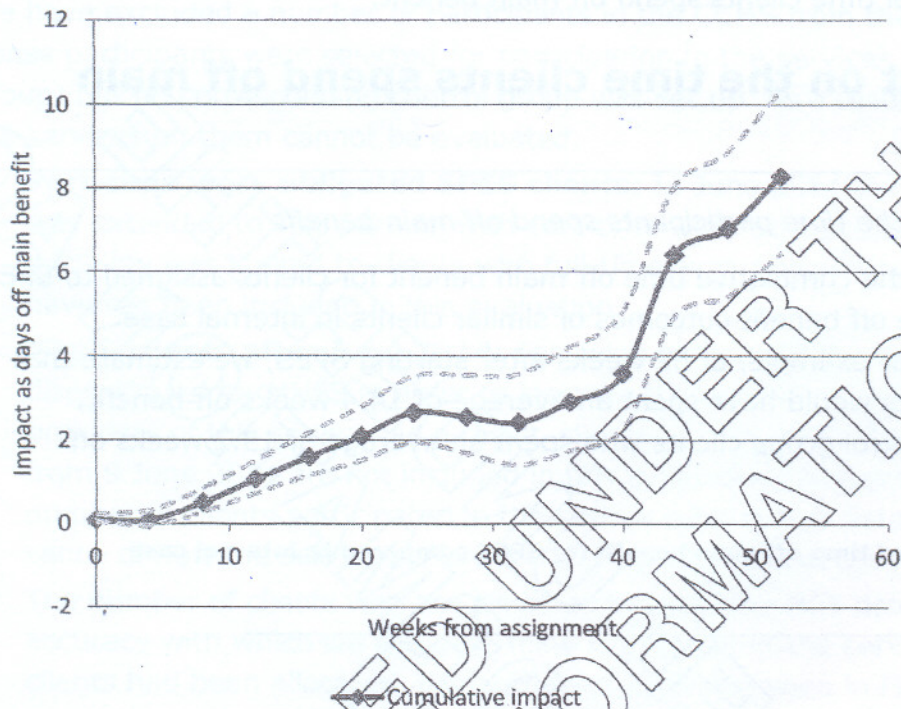


Figure 2 shows the difference in time off main benefit between the control and treatment group and represents the estimated impact of SPES on participants' cumulative time off main benefit. We see a steady increase in the cumulative time off main benefit if clients are in SPES compared to being assigned to

internal case management. After 52 weeks, we estimate that SPES had on average increased the time off main benefit by 8 (± 1.8) days relative to being in internal case management.

Figure 2: Estimated impact of SPES over being in internal case management



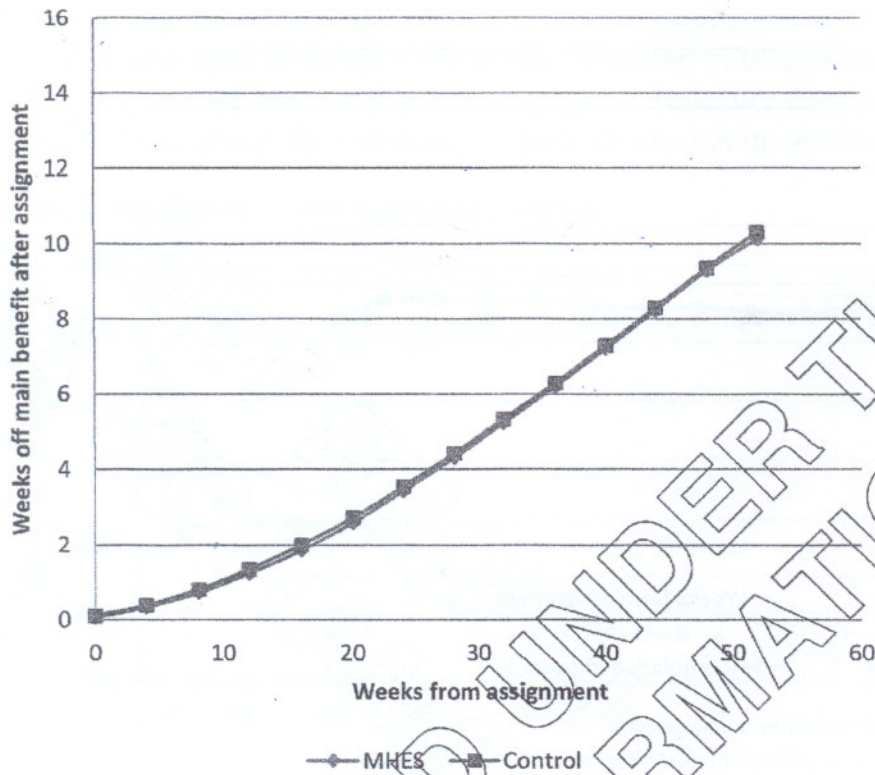
1: Increase in time off main benefit from assignment.
Dotted lines indicate the 95% confidence interval for the impact of the service

Note: Results from 52 weeks have been suppressed because the sample size of either the treatment group or control group is too small to reliably report on outcomes over longer periods. In subsequent updates to this analysis we will be able to extend this follow-up period.

MHES does not increase the time clients spend off main benefit

Figure 3 shows the time off main benefit for clients assigned to MHES compared to the off benefit outcomes of similar clients in internal case management. For example, at 52 weeks after starting MHES, we estimate that both MHES participants and control clients would have spent an average of 10 weeks off benefit.

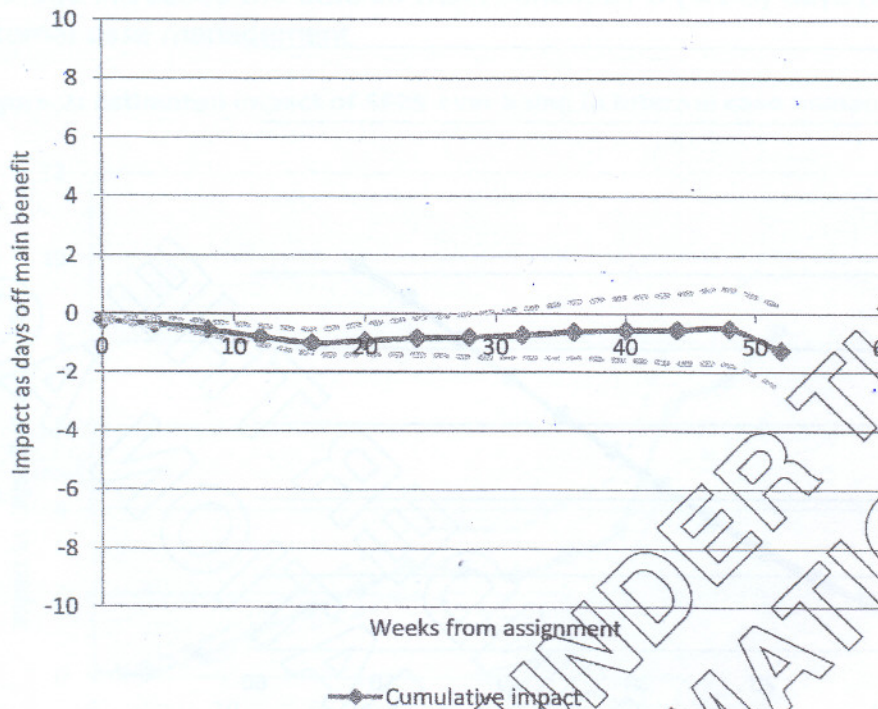
Figure 3: Estimated time off main benefit for MHES compared to internal case management



We can see from Figure 3 that off benefit outcomes are very similar for both the MHES participants and clients who are case managed internally.

Figure 4 shows the impact of MHES relative to internal case management (i.e. the difference between MHES and internal case management outcomes in Figure 3). At 52 weeks we estimate that MHES decreased the cumulative time off main benefit by an average of 1 (± 1.4) days. We can also see from Figure 4 that the impact of the MHES is slightly negative on average for all periods up to 52 weeks following assignment.

Figure 4: Estimated impact of MHES over being in internal case management



1: Increase in time off main benefit from assignment.

Dotted lines indicate the 95% confidence interval for the impact of the service

Note: Results from 52 weeks have been suppressed because the sample size of either the treatment group or control group is too small to reliably report on outcomes over longer periods. In subsequent updates to this analysis we will be able to extend this follow-up period.

Duration in intensive case management services

Analysis of the time that clients spend in intensive case management services

At the point of being assigned to the control group, the control group for the SPES trial was predominantly made up of clients in WFCM-Gen (WFCM-Gen (63%), GCM (9%) and WSS (27%)). The proportions at the time of assignment have remained fairly constant over the 18 month period.⁸ As such, the evaluation is comparing the SPES service predominantly with medium to high intensity Work and Income services.

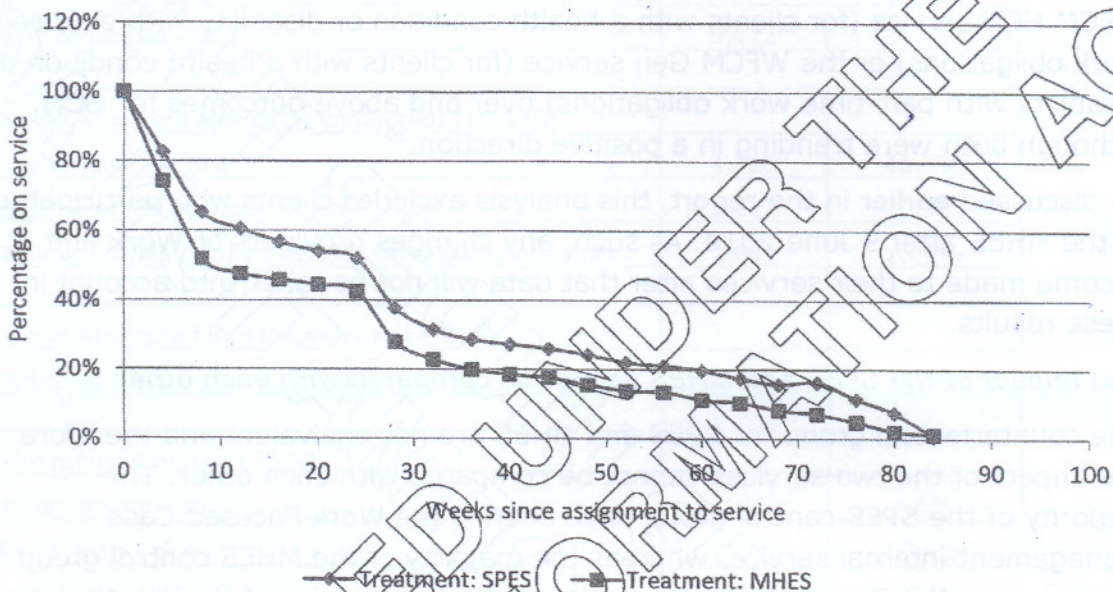
At the point of being assigned to the control group, the control group for the MHES trial was predominantly made up of clients in GCM (GCM (82%), WFCM-Gen and WFCM-HCD (18%)). The proportions at the time of assignment have remained fairly constant over the 18 month period. The evaluation is comparing the MHES service predominantly with the lowest intensity Work and Income service.

⁸ Clients in the control group move between various internal services as eligibility allows.

Survival of treatment group clients on Contracted Case Management service

Clients exited from both CCMS services in large proportions in the weeks following referral. In the case of SPES 35% of clients exited in the first eight weeks. In the case of MHES 48% of clients exited in this period. These clients will have received very little provider support. However they are still included in the treatment group for our analysis (see discussion in section 2.5).

Figure 5: Survival of clients remaining in CCMS



Discussion of results

SPES

We do not know the reason SPES is achieving significantly better outcomes than the internal Work and Income services, especially given the comparison group for SPES is already experiencing an effective service.⁹ The impact of the SPES is over and above this effect. A qualitative evaluation of the SPES would potentially be able to answer the 'how' and 'why' type questions behind these results e.g. how practices differ between providers and internal case management, and why client behaviours differ between the two.

MHES

⁹ MSD (2015) Effectiveness of intensive case management services (WFCM and WSS) on off benefit outcomes at one year: initial results (version1), Ministry of Social Development

One possibility for the outcomes from the MHES is the fact that a large proportion of clients who were referred to the service exited before the provider had much (if any) time to work with them (see Figure 5). These exited clients remain part of the treatment group (see discussion in section 2.5), but they actually received an internal Work and Income service for the majority of the time.

In addition, we note that the assessment of the impact of the Service Delivery Model at one year also showed no significant difference for the more intensive WFCM HCD service (for clients with a health condition or disability with deferred work obligations) or the WFCM Gen service (for clients with a health condition or disability with part-time work obligations) over and above outcomes for GCM, although both were trending in a positive direction.¹⁰

As discussed earlier in the report, this analysis excludes clients who participated in the MHES after 9 June 2014. As such, any changes providers or Work and Income made to their services after that date will not be taken into account in these results.

The impact of the SPES and MHES cannot be compared with each other

The counterfactual group for SPES and MHES are not equivalent and therefore the impact of the two services cannot be compared with each other. The majority of the SPES control group have been in the Work Focused Case Management internal service, whereas the majority of the MHES control group have been in the General Case Management internal service. Adjusting the counterfactual group for time spent in each internal service is a complex task. This issue will be addressed in the three year evaluation analysis.

¹⁰ MSD (2015) Effectiveness of intensive case management services (WFCM and WSS) on off benefit outcomes at one year: initial results (version1), Ministry of Social Development

Appendix

The following monitoring data is as at 1 April 2015

SPES	Count	Percentage
Placed on call list	15,568	
Able to be contacted	10,146	65.2%
Unable to be contacted	5,422	34.8%
Of those who were able to be contacted: (10,146)		
Opted into the service	4,916	48.5%
Opted out of the service	3,622	35.7%
Unable or unwilling to answer the amenability question	1,608	15.9%
Of those who opted into the service: (4,916)		
Referred to service	3,560	72.4%
Of the referred group: (3,562)		
Declined by provider	164	4.6%
Exited from service	2,152	60.4%
Currently enrolled	1,246	35%

MHES	Count	Percentage
Placed on call list	14,660	
Able to be contacted	11,732	80%
Unable to be contacted	2,928	20%
Of those who were able to be contacted: (11,732)		
Opted into the service	5,186	44.2%
Opted out of the service	4,498	38.3%
Unable or unwilling to answer the amenability question	2,048	17.5%
Of those who opted into the service: (5,186)		
Referred to service	3,730	71.9%
Of the referred group: (3,730)		
Declined by provider	48	1.3%
Exited from service	2,672	71.6%
Currently enrolled	1,010	27.1%